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Issue Date: 09 June 2005

In the Matter of:
BOBBY CHILDERS
Claimant
v. Case No. 2004-BLA-05126

BOB CHILDERS TRUCKING
Employer
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Before: Daniel F. Solomon
Administrative Law Judge

DECISION AND ORDER
DENIAL of CLAIM[1]
JURISDICTION AND CLAIM HISTORY

This case comes on a request for a hearing pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§ 901 *et seq*. (the Act) (DX-53)[2] dated July 21, 2003.[3]

Procedural Background

A hearing was held on May 12, 2004, in Bristol, Virginia. The Claimant is represented by Joseph Wolfe, Esq., Norton, Virginia. Bob Childers Trucking (hereinafter "Employer") is represented by Russell Vern Presley, II, Esq., Street Law Firm, LLP, Grundy, Virginia. An appearance was entered for the Director, OWCP, who was not represented at the hearing. The Claimant appeared at the hearing and testified. Fifty-eight (58) Director's exhibits, DX-1

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[1] 20 C.F.R. § 725.477, 5 C.F.R. § 554-7 (Administrative Procedure Act), and also 20 C.F.R. § 725.479 Finality of decisions and orders.

[2] References to "ALJX", "CX", "DX" and "EX" refer to the exhibits of the Administrative Law Judge, Claimant, Director and the Employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

[3] And the regulations at 20 C.F.R. Ch. VI, Subchap. B (the Regulations).

through DX-58,[4] two (1) Claimant's exhibits, CX 1 and CX 2,[5] and thirteen (13) Employer's exhibits, EX 1 through EX 13,[6] were admitted into evidence at the formal hearing. By leave granted at the hearing, the Employer submitted two additional exhibits. These exhibits are admitted into the record as Employer's Exhibits 14 and 15, EX-14 and EX-15.

The Claimant, Bobby Childers, filed his first claim for benefits under the Act on May 20, 1993. (DX-28-1). This claim was denied by the District Director on October 28, 1993 (DX-28-26), and, pursuant to the Claimant's request, this claim was referred to the Office of Administrative Law Judges for a formal hearing. (DX-28-48) On February 23, 1996, Administrative Law Judge Nicodemo De Gregorio issued a Decision and Order Awarding Benefits. (DX-28-60). On appeal by the Employer, the Benefits Review Board vacated the award of benefits and remanded for reconsideration. ***Childers v. Island Creek Coal Co. & Bob Childers Trucking Co., Inc.,*** BRB No. 96-0745 BLA (Jan. 28, 1997) (unpub.) (DX-28-68).[7] On remand, Administrative Law Judge Clement J. Kichuk denied benefits, finding that the Claimant failed to establish the existence of pneumoconiosis. (DX-28-70). Administrative Law Judge Kichuk found that, while the Claimant was totally disabled, he failed to establish pneumoconiosis or disability causation. This decision was affirmed by the Board. ***Childers v. Island Creek Coal Co. & Bob Childers Trucking Co., Inc.,*** BRB No. 98-0405 BLA (Mar. 15, 1999) (unpub.) (DX-28-75).

The Claimant filed the instant claim on September 20, 2000. (DX-1). On June 13, 2001, the District Director issued a proposed decision and order awarding benefits. (DX-22). The Employer requested a formal hearing, and this claim was referred to this Office on August 6, 2001. (DX-29). On November 21, 2002, Administrative Law Judge Stuart Levin issued a Decision and Order denying benefits. (DX-41). The administrative law judge found that the Claimant had failed to establish any of the elements of entitlement that had been previously adjudicated against him in the denial of his first claim.

The Claimant appealed to the Board. While his direct appeal was pending, the Claimant on January 15, 2003 petitioned for modification. (DX-47). 20 C.F.R. § 725.310. In light of this filing, the Board dismissed the Claimant's appeal without prejudice, and remanded the claim to the District Director for modification proceedings. ***Childers v. Bob Childers Trucking Co., Inc.,*** BRB No. 03-0238 BLA (Feb. 13, 2003) (Order) (DX-48). On June 24, 2003, the District Director issued a *Proposed Decision and Order Denying Request for Modification*. (DX-52). This claim was referred to this Office as noted above for formal adjudication.

Hearing Testimony

Mr. Childers testified at the hearing. (Tr. 15-27). He stated that he needs the assistance

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[4] At Tr. 7.

[5] At Tr. 11-14.

[6] At. Tr. 29.

[7] The Board affirmed as unchallenged the administrative law judge's findings of total respiratory disability and that Bob Childers Trucking was the properly designated responsible operator. ***Childers v. Island Creek Coal Co. & Bob Childers Trucking Co., Inc.,*** BRB No. 98-0405 BLA (Mar. 15, 1999) (unpub.) (DX-28-75).

of oxygen to breathe, and that he suffers chest pains. (Tr. 16-17). He has been under the care of Dr. Robinette. On cross-examination, Mr. Childers recounted that he had previously been under the care of Dr. Baxter, but that a Dr. Kabaria had first told him that he was disabled by black lung in 1990. (Tr. 19). The Claimant said that he could get his medical records that supposedly related this information to him, although there appears to be no indication that he actually had received a written assessment of total disability due to pneumoconiosis. When he applied for Social Security Disability benefits, Mr. Childers testified that the SSA apparently received his records directly from Dr. Kabaria and approved his claim. (Tr. 20-21). The Claimant also received benefits in the amount of $2,800 on a "state rock dust claim." (Tr. 22).

Mr. Childers acknowledged that he smoked for approximately fifty years at the rate of one pack every day. (Tr. 22). He denied smoking within the past five years. (Tr. 23). He testified that he had worked for the Island Creek Coal Company for ten years until 1977, and then operated his own trucking company until 1990. (Tr. 24).

On redirect examination, Mr. Childers acknowledged that he had hauled finished coal from processing plants. (Tr. 25-27). He also testified that he would haul coal to both sides of the Ohio River – into Kentucky and West Virginia, but that he would run coal from Pikeville to Catlettsburg on the Ohio River. (Tr. 25-27). He testified that his wife was present, but that he has no dependent children.[8] (Tr. 18).

ISSUES

A miner must prove that (1) he suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) he is totally disabled, and (4) his total disability is caused by pneumoconiosis. ***Gee v. W. G. Moore and Sons***, 9 B.L.R. 1-4 (1986) (en banc); ***Baumgartner v. Director, OWCP,*** 9 B.L.R. 1-65 (1986) (en banc). *See* ***Mullins Coal Co., Inc. of Virginia v. Director, OWCP*****,** 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987). The failure to prove any requisite element precludes a finding of entitlement. ***Anderson v. Valley Camp of Utah*****, Inc.,** 12 B.L.R. 1-111 (1989); ***Perry v. Director*****, *OWCP*****,** 9 B.L.R. 1-1 (1986) (*en banc*).

This decision relates to the modification of a duplicate claim filed on September 20, 2000. DX-1. Because the claim at issue was filed after March 31, 1980, the regulations at 20 C.F.R. Part 718 apply.[9] 20 C.F.R. § 718.2 (2002). In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing and the arguments of the parties.[10]

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[8] I find that the Claimant's wife is dependent for purposes of augmentation of benefits.

[9] The Department of Labor has amended the regulations that implement the Act. *See* 65 Fed. Reg. 80,045-80,107 (2000). The adjudication of this claim is subject to regulations as amended effective January 19, 2001 that relate to the standards of entitlement. 20 C.F.R. § 718.2 (2001). Unless otherwise indicated, citations are to the regulations as amended. Because this claim was "pending" on January 19, 2001, however, the provisions of the amended regulations that both govern "subsequent claims," modification and that limit the development of medical evidence do not apply to the consideration of claimant's petition for modification of the 2000 duplicate claim. 20 C.F.R. § 725.2(c). *See* 68 Fed. Reg. 69935 (Dec. 15, 2003). A claim shall be considered "pending" if it was not finally denied more than one year prior to January 19, 2001, the effective date of the amended regulations. 20 C.F.R. § 725.2(c).

[10] Although all of the duplicate claim record is to be reviewed *de novo*, the evidence that was previously reviewed by Administrative Law Judge Levine and set forth in his decision and Order will not again be listed herein in great detail unless necessary for a consideration of an issue. Without adopting the findings and conclusions by Judge Levine, I do incorporate by reference those lists of exhibits and evidence as set forth in the prior decision. *See*

The specific issues for adjudication in this case are:

1. Whether this duplicate claim is timely;
2. Whether Claimant has proven a change in condition or a mistake in determination of fact in the prior denial of this duplicate claim;
3. Whether the evidence establishes a material change in conditions;
4. Whether the medical evidence establishes that the Claimant suffers from pneumoconiosis;
5. If so, whether the Claimant's pneumoconiosis arose at least in part out of his coal mine employment;
6. Whether the Claimant suffers from a totally disabling pulmonary or respiratory impairment;
7. Whether any total respiratory disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(c);
8. Whether there are any dependents for purposes of augmentation of benefits.

STIPULATION AND WITHDRAWAL OF ISSUES

At the hearing, Employer's counsel withdrew the issues of whether the Claimant was a miner, and was so occupied after 1969, and the issue of insurance coverage. (Tr. 7). The parties stipulated to 20 years of coal mine employment. (Tr. 6).

In its post-hearing brief, the Employer has acknowledged that the "evidence in connection with claimant's duplicate application for benefits clearly established that he had a totally disabling respiratory or pulmonary impairment." Although conceding at the hearing that Mr. Childers was a "miner," the Employer now, as part of its challenge to its designation as the responsible operator, contends that Mr. Childers, as shown by his most recent testimony, only transported processed coal - activities that do not constitute qualifying coal mine employment. We shall address this issue below.

BURDEN OF PROOF

"Burden of proof," as used in the this setting and under the Administrative Procedure Act[11] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[12] The drafters of the APA used the term "burden of proof" to

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generally, ***Wheeler v. Apfel*****,** 224 F.3d 891, 895 n. 3 (8th Cir. 2000). The pulmonary function and arterial blood gas tests will also not be reproduced in detail. These tests have been carefully evaluated, for while the parties do not dispute the extent of the Claimant's total respiratory disability, such tests are also relevant documentation in the determination of whether a claimant suffers from pneumoconiosis.

[11] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[12] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v.***

mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [***Ondecko***], 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[13]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

LENGTH OF COAL MINE EMPLOYMENT

The length of the Claimant's qualifying coal mine employment is no longer contested as an issue, with the parties stipulating to 20 years in the mines. I find that this stipulation is supported by the record, and therefore credit Mr. Childers with 20 years of coal mine employment.

MEDICAL EVIDENCE

The following medical evidence has been submitted pursuant to the Claimant's request for modification[14]:

X-Ray Interpretations

X-RAY DATE	***READING DATE***	***EXH.***	***PHYSICIAN/ QUALIFICATIONS***[15]	***INTERPRETATION***
06-24-99	06-24-99	CX-2	Mullins	"pulmonary hyperinflation with chronic interstitial lung disease predominantly involving the

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Director, OWCP [***Sainz***], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[13] Also known as the risk of nonpersuasion, *see* 9 J. Wigmore, **Evidence** § 2486 (J. Chadbourn rev. 1981).

[14] In order to assess whether the Claimant is entitled to reopen this duplicate claim pursuant to his request for modification, I must consider the duplicate claim record as a whole to determine whether the denial of the duplicate claim constitutes a mistake in determination of fact. I shall also review of the new "modification" evidence to assess whether it demonstrates a change in Mr. Childers' condition.

[15] The credentials of interpreters of the x-rays are signified as "A" for an A-reader of x-rays, "B" for a B-reader, "BCR" for a board-certified radiologist, and "B/BCR" for a radiologist who possesses dual qualifications. A physician who is "board-certified" has received certification in radiology by the American Board of Radiology or the American Osteopathic Association. 20 C.F.R. § 718.202(a)(1)(ii)(C). *See* ***Staton v. Norfolk & Western Railway Co.***, 65 F.3d 55, 57, 19 B.L.R. 2-271 (6th Cir. 1995).

A "B reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Occupational Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to x-ray readings performed by "B-readers" over interpretations by physicians who possess no radiological qualification. *See* ***LaBelle Processing Company v. Swarrow***, 72 F.3d 308, 20 B.L.R. 2-76 (3d Cir. 1995).

An administrative law judge may properly defer to the readings of the physicians who are both B-readers and Board-certified radiologists. ***Roberts v. Bethlehem Mines Corp.***, 8 B.L.R. 1-211 (1985). *See* ***Zeigler Coal Co. v. Director, OWCP*** **[*Hawker*]**, 326 F.3d 894, 899 (7th Cir. 2003). Finally, a radiologist's academic teaching credentials in the field of radiology are relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See* ***Worhach v. Director, OWCP***, 17 B.L.R. 1-105 (1993). Although academic experience does not require that a radiologist's interpretation must be credited. *See* ***Chaffin v. Peter Cave Coal Co.***, 22 B.L.R. 1-294 (2003).

				lung bases."
06-24-99	01-12-01	DX-18	Wheeler, B/BCR[16]	negative for pneumoconiosis
06-24-99	01-12-01	DX-18	Scott, B/BCR[17]	negative for pneumoconiosis
06-24-99	02-06-02	DX-34	Castle, B	negative for pneumoconiosis
03-06-00	03-06-00	CX-2	Coburn	"... lung fields free of any active infiltrate." No change from previous exam.
03-06-00	01-12-01	DX-18	Wheeler, B/BCR	negative for pneumoconiosis
03-06-00	01-12-01	DX-18	Scott, B/BCR	negative for pneumoconiosis
03-06-00	02-06-02	DX-34	Castle, B	negative for pneumoconiosis
11-07-00	11-07-00	DX-12	Forehand, B	2/1, s,t
11-07-00	11-29-00	DX-13	Ranavaya, B	0/1, s,s
11-07-00	12-19-00	DX-14	Barrett, B/BCR	negative for pneumoconiosis
11-07-00	10-04-01	DX-33	Wheeler, B/BCR	negative for pneumoconiosis
11-07-00	10-08-01	DX-33	Scott, B/BCR	negative for pneumoconiosis
05-04-01	05-18-01	DX-21	Fino, B	negative
05-04-01	06-19-01	DX-26	Wheeler, B/BCR	negative for pneumoconiosis
05-04-01	06-14-01	DX-26	Scott, B/BCR	negative for pneumoconiosis
05-04-01	02-06-02	DX-34	Castle, B	0/1, t,s
10-19-01	10-22-01	DX-35[18]	DePonte, B/BCR	
10-19-01	05-07-02	DX-39	Wheeler, B/BCR	negative for pneumoconiosis
10-19-01	05-07-02	DX-39	Scott, B/BCR	negative for pneumoconiosis
10-19-01	05-07-02	DX-39	Scatarige, B/BCR[19]	negative for pneumoconiosis
12-04-01	12-04-01	DX-49	Patel, B/BCR	1/1, s,t, quality 2
12-04-01	09-09-03	DX-54	Scatarige, B/BCR	negative for pneumoconiosis
12-04-01	09-10-03	DX-54	Wheeler, B/BCR	negative for pneumoconiosis
12-31-01	10-08-03	EX-3	Scatarige, B/BCR	negative for pneumoconiosis, quality 2, emphysema,

[16] Dr. Wheeler has also held various academic positions in the Department of Radiology at the Johns Hopkins School of Medicine. Most recently, Dr. Wheeler has been an Associate Professor of Radiology since 1974, and prior to that an assistant professor of radiology since 1969. (DX-18).

[17] Dr. Scott has also held various academic positions in the Department of Radiology at the Johns Hopkins School of Medicine. Most recently, Dr. Scott has been an Associate Professor of Radiology since 1984, and prior to that an assistant professor of radiology between 1978 and 1984. (DX-18).

[18] This reading is purportedly a narrative that was submitted as Claimant's Exhibit 1 before Administrative Law Judge Levine. The Employer cites to DX-35 in describing this x-ray reading as a narrative. Judge Levine characterized it as an illegible narrative interpretation. (DX-41 at 3). It does not appear in the current Director's Exhibit 35. Assuming that Dr. DePonte rendered a positive, and classified, interpretation of this film, I would nevertheless find that her reading does not outweigh the negative rereadings of this film by Drs. Wheeler, Scott and Scatarige.

[19] Dr. Scatarige has been an Assistant Professor of Radiology at the Johns Hopkins School of Medicine since 2000, and prior to that an Associate Clinical Professor of Radiology at the Medical College of Virginia from 1990 to 1995. (DX-39).

12-31-01	10-08-03	EX-3	Wheeler, B/BCR	"decreased lung markings both upper lobes, probably due to bullae." ... granulomata no pneumoconiosis, quality 2, emphysema, "decreased upper lung markings compatible with emphysema" ... indications compatible with "healed histoplasmosis"
04-23-03	04-23-03	CX-2	Mullens	... lungs hyperinflated ... otherwise clear ...
09-10-03	10-01-03	EX-7	Castle	1/0
04-02-04	04-10-04	CX-1	DePonte, B/BCR	1/1, quality 2, emphysema
04-02-04	07-02-04	EX-14	Scott, B/BCR	negative for pneumoconiosis

Medical Opinions and Reports

CT Scans

Dr. Richard Mullens. Dr. Mullens read a CT scan taken of the thorax region on December 31, 2001, and reported that this test showed "centrilobular emphysema. Chronic interstitial fibrosis involving the subpleural interstitium of both lung bases. Old healed granulomatous disease." (CX-2). A second CT scan was taken that day, focused on the lateral chest area, and showed "[p]ulmonary hyperinflation. There is no evidence of a hilar mass." Aside from the hyperinflation, the lungs were considered "clear."

Dr. Ernest L. Coburn. Dr. Coburn examined a CT scan taken on July 3, 2002. (CX-2). He reported that the procedure detected "evidence of interstitial fibrosis consistent with coal workers' pneumoconiosis with subpleural interstitial changes. There is also centrilobular emphysematous changes" and "evidence of old granulomatous disease."

Dr. John C. Scatarige. Dr. Scatarige examined a helical CT of the chest, dated July 3, 2002. (EX-1). He reported that the CT scan revealed "[n]o small lung opacities to indicate CWP or silicosis." He did find emphysema and calcifications "compatible with histoplasmosis." Dr. Scatarige also observed "[m]inimally increased lung markings in dependent portions of both lower lungs, like normal 'dependent density.'" In an "Addendum to CT of 12/31/2001," Dr. Scatarige reported, *inter alia*, "[n]o evidence of CWP or silicosis," "[d]iffuse emphysema," "calcified granulomata in left mid lung," "[c]alcified lymph nodes in mediastinum and hila and granulomata in spleen. Findings likely due to healed histoplasmosis."

Dr. Paul S. Wheeler. Dr. Wheeler reviewed CT scans of the chest that were on December 31, 2001 (EX-2), and July 3, 2002 (EX-2). He reported that the "mediastinal settings [for the earlier film] are inadequate for detecting lung diseases aside from masses." The July 3, 2002 CT scan revealed "no pneumoconiosis," but did detect "emphysema with decreased and distorted upper lung markings." In a later interpretation of the December 31, 2001 CT scan, Dr. Wheeler opined: "5 mm lung and mediastinal settings: no pneumoconiosis." He also found calcified granulomata. (EX-4).

Medical Examination Reports

Dr. James R. Castle. Dr. Castle evaluated the Claimant on September 10, 2003 and

issued his report on February 9, 200[4]. (EX-7). The Claimant told Dr. Castle that he had suffered from shortness of breath since before 1990, when he was unable to pass a test for a commercial driver's license and had to stop work. Mr. Childers had been using oxygen for the previous five to six years. He also said that he could walk only 25-30 feet on level ground, or climb one flight of steps, without stopping because of shortness of breath. Mr. Childers complained that he has a productive morning cough, uses an inhaler for relief, but does not wheeze.

Dr. Castle recorded a smoking history of 49 pack/years. Mr. Childers also claimed that he worked underground in the mines for 17 years until 1977, when he quit and started his own trucking company. This latter work involved heavy labor.

On physical examination of the chest, Dr. Castle observed "normal percussion note and normal tactile fremitus. He had equal breath sounds throughout. I heard no rales, rhonchi, wheezes, rubs, crackles, or crepitations. Breath sounds were diminished throughout. He also had prolongation of the expiratory wheeze." There was no cyanosis, clubbing or edema on examination of the extremities.

Dr. Castle interpreted a chest x-ray as showing 1/0 profusions, although he thought that the changes did not indicate pneumoconiosis. The doctor interpreted ventilatory results as indicative of the "presence of tobacco smoke induced emphysema with a markedly significant asthmatic component." The pulmonary function studies also showed a "markedly reversible airway obstruction." The arterial blood study results showed an elevated carboxyhemoglobin level of 2.9%. Dr. Castle concluded, based on his examination and review of the clinical data:

1. Insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis.
2. Tobacco smoke induced chronic obstructive pulmonary disease with a very significant asthmatic component.
3. Probable obstructive sleep apnea syndrome.
4. Moderate hypoxemia.
5. Coronary artery disease.
6. Abnormal electrocardiogram ...
7. Abnormal chest x-ray was significant cardiomegaly.
8. Exogenous obesity.
9. Non-insulin dependent diabetes, by history.

After reviewing the Claimant's medical records, including medical reports and notes from earlier examinations, Dr. Castle maintained his opinion that the Claimant does not suffer from pneumoconiosis. He cited as risk factors for Mr. Childers' pulmonary symptoms his 17 years underground and coal truck driving, the 49 years smoking and asthma. With respect to the latter, Dr. Castle observed that a sensitivity to flowers, hair sprays and a reversibility on pulmonary function testing "are all consistent with a significant asthmatic process." Dr. Castle added that two additional risk factors were cardiac disease and obesity.

He explained his opinion that the Claimant does not suffer from pneumoconiosis:

> At no time did he demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process such as would be expected with coal workers' pneumoconiosis. He did not have the consistent finding of rales, crackles, or crepitations. He did have wheezing periodically, decreased breath sounds, and prolongation of the expiratory phase. These findings are indicative of

tobacco smoke induced airway obstruction and bronchial asthma.

Despite his reading of "1/0" on a chest x-ray, Dr. Castle denied that the Claimant had radiographic evidence of pneumoconiosis, although he checked "yes" to the box that indicated whether he found "parenchymal abnormalities consistent with pneumoconiosis." He explained that he saw "irregular type opacities" that were indicative of "heavy tobacco abusers and [obesity]." Dr. Castle continued:

> the physiologic studies that were done most recently showed evidence of moderate, markedly reversible airway obstruction associated with hyperinflation, gas trapping, and reduction in the diffusing capacity. These findings are indicative of tobacco smoke induced pulmonary emphysema with a very significant asthmatic component. When coal workers' pneumoconiosis causes impairment, it generally does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect. These were not findings in this case. In the past he has demonstrated a significant degree of reversibility of his pulmonary function studies as well. There appears to have been a minimal decline in the forced vital capacity since the previous studies. The FEV1 has remained essentially unchanged. It is my opinion that these changes are due to the asthmatic component of his airway obstruction and not due to any coal mine dust induced lung disease.
>
> The arterial blood gases that have been done continue to show significant hypoxemia on room air. It is my opinion that this degree of hypoxemia is related to his tobacco smoke induced chronic obstructive pulmonary disease and asthma. It is also contributed to most likely by obstructive sleep apnea syndrome and obesity.

Dr. Castle emphasized that the Claimant did not have pneumoconiosis, and further opined that, even if Mr. Childers was afflicted with the disease, it played no role in his pulmonary or respiratory impairment. Dr. Castle is board certified both in internal medicine and pulmonary disease, and is a B-reader. He has been Clinical Professor of Medicine at the University of Virginia College of Medicine since 1993, and before that a Clinical Associate Professor of Medicine at that institution from 1977 to 1993. Dr. Castle has also been engaged in the private practice in the field of pulmonary medicine since 1977. (EX-8).

The Employer recorded Dr. Castle's deposition testimony on April 19, 2004. (EX-13). The principal subject of this testimony was Dr. Castle's examination of Mr. Childers on September 10, 2003 and his other evaluation reports. (EX-13 at 10). He explained his opinion that the Claimant does not have pneumoconiosis, citing the presence instead of a "smoke-induced chronic obstructive pulmonary disease with a very significant reversibility to that process or an asthmatic component." (EX-13 at 12). Dr. Castle noted that he relied in part on an occupational history of 17 years of underground mining followed by 22 years hauling coal. Mr. Childers also related to Dr. Castle a 49 pack/year smoking history.

Dr. Castle further explained that smoking would cause "an obstructive type of respiratory disease that may have some degree of reversibility with it[.]" (EX-13 at 14). The Claimant also appeared to have indications of coronary artery disease as shown on an electrocardiogram and the chest x-ray, and sleep apnea. The Claimant's obesity would also constitute a source of his pulmonary or respiratory complaints.

Dr. Castle elaborated on his interpretation of the chest x-ray which he had read as

showing 1/1 opacities. He emphasized that they were "irregular type opacities in the middle and lower lung zones, and those are not the findings that one sees with coal workers' pneumoconiosis." The opacities he saw were, instead, typically seen in patients who are overweight, heavy smokers, have recurrent infections, but are not due to pneumoconiosis. (EX-13 at 19-20). Ventilatory studies showed a "very markedly reversible airway obstruction," but Mr. Childers "nevertheless had moderate airway obstruction." The doctor commented that the complaint of sensitivity to flowers and hair sprays would indicate some aspect of asthma. With respect to the results of the resting arterial blood gas study, the Claimant showed a "significant hypoxemia" and "minimally elevated carbon dioxide level." These factors also persuaded Dr. Castle that the Claimant's airway obstruction was due to smoking.

Dr. Castle also explained that the reversibility as shown on the pulmonary function testing would not indicate a coal mine induced airway obstruction. He pointed out that "[c]oal mine induced airway obstruction does not reverse, and it is because of the nature of the scarring process and the irreversible nature of coal workers' pneumoconiosis." (EX-13 at 27). He further described an impairment caused by coal workers' pneumoconiosis as a "mixed, irreversible obstructive and restrictive ventilatory defect[.]" This was not present in this case, and Mr. Childers' respiratory impairment is not related in whole or in part to coal mine dust exposure, nor "significantly related to or substantially aggravated by his prior coal mine dust exposure." (EX-13 at 28). On cross-examination, Dr. Castle testified that coal mine dust exposure can cause focal emphysema, but the emphysema seen here is not of that type. (EX-13 at 32).

Dr. A. Dahhan. Dr. Dahhan conducted a record review and reported his conclusions on March 15, 2004. (EX-9). He had earlier reviewed the Claimant's records on December 20, 2001 (DX-33) and March 22, 2002. (DX-38). He concluded that the records now show that the Claimant "has pulmonary tuberculosis requiring treatment with anti-tuberculosis drugs, that could be responsible for abnormalities noted on the chest x-ray, which could have been mis-read as pneumoniotic opacities." Dr. Dahhan concluded that the Claimant is totally disabled as shown by clinical tests, and that this disability "continues to demonstrate significant response to bronchodilator therapy[.]" He further opined that "Mr. Childers' pulmonary disability has resulted from his previous smoking habit." He cited the significant response to bronchodilator therapy as pointing to a possible hyperactive airway disease, and opined as well that Mr. Childers appeared to be suffering from sleep apnea and TB.

None of the Claimant's conditions were "caused by, or related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis[,]" he wrote. (EX-9). In his December 20, 2001 report, Dr. Dahhan observed that the Claimant's "obstructive ventilatory defect demonstrates variable response to bronchodilator therapy, indicating that it is not a fixed defect, another finding that argues against the condition being caused by coal dust exposure." (DX-33). Dr. Dahhan is board certified in internal medicine and pulmonary medicine. He is also a B-reader, and has been in private medical practice since 1986 after a 12-year tenure in the Department of Pulmonary Medicine at the Daniel Boone Clinic. (EX-10).

Dr. Gregory J. Fino. Dr. Fino likewise has reviewed the Claimant's medical records on more than one occasion. In his latest report, dated April 21, 2004, he reiterated his conclusions that the Claimant "has severe respiratory impairment related to cigarette smoking, and I believe that coal mine dust inhalation did not contribute to his overall disability." (EX-11). Dr. Fino also reiterated that coal workers' pneumoconiosis is not present. Dr. Fino is board-certified in internal medicine, with a subspecialty in pulmonary disease, and is a B-reader. (EX-12).

Dr. Fino examined the Claimant on May 4, 2001, and reviewed other medical evidence. In his report, dated May 18, 2001, Dr. Fino diagnosed severe emphysema, and chronic obstructive bronchitis due to cigarette smoking. He concluded:

> There are two potential risk factors for [the Claimant's total respiratory] disability: coal mine dust exposure and smoking. In my opinion, what we are seeing in the case can be attributed to cigarette smoking. I am certainly aware that in some miners coal mine dust inhalation has been shown to cause an obstructive abnormality. However, careful analysis of the information regarding the association of obstruction and mining shows a minimal reduction in the FEV1 as a result of coal mine dust inhalation. ...
>
> The pattern of abnormalities is quite consistent with cigarette smoking. ...

(DX-21). Dr. Fino opined that the Claimant did not have pneumoconiosis, or any occupationally acquired pulmonary condition.

The Employer secured the deposition testimony of Dr. Fino on February 15, 2002. (DX-37). Dr. Fino testified that the Claimant is severely impaired, but asserted that he does not suffer from coal workers' pneumoconiosis. (DX-37 at 11). He said that when he examined the Claimant, he observed decreased breath sounds and that Mr. Childers took a long time to exhale – signs of an obstructive abnormality but not typical of an individual suffering from pneumoconiosis. (DX-37 at 13). He noted that the medications that have been prescribed in this instance are not helpful for an irreversible disease like pneumoconiosis. He thought it significant that the ventilatory test results excluded restriction and pulmonary fibrosis.

Dr. Fino explained his conclusion that the Claimant does not have pneumoconiosis because a diagnosis would not be substantiated by the objective evidence. He cited a dramatic drop in the FEV1 in seven years as a "rapid reduction consistent with smoking." He also pointed out that the reduction in diffusion capacity also points to the effects of smoking.

On cross-examination, Dr. Fino acknowledged that coal mine dust inhalation can cause emphysema, chronic obstructive pulmonary disease, and that it can act in concert with smoking to cause emphysema. (DX-37 at 21).

Dr. Donald L. Rasmussen. Dr. Rasmussen presented a report based on his December 4, 2001 pulmonary evaluation of Mr. Childers. (DX-49). The Claimant presented with complaints of wheezing, progressive shortness of breath, dyspnea after walking 100 feet and a chronic productive cough. The wheezing would be exacerbated by "flowers, hair sprays, etc." On physical examination of the chest, Dr. Rasmussen observed normal breath sounds. He found no rales, rhonchi or wheezes. Extremities showed no edema and there was no clubbing.

Dr. Rasmussen incorporated the results of clinical testing, including a positive interpretation for pneumoconiosis – "1/1" – as read by Dr. M. Patel. (DX-49). Pulmonary function studies revealed a moderate, partially reversible obstructive ventilatory impairment with a moderately reduced maximum breathing capacity. Resting arterial oxygen tension was "markedly reduced and [the Claimant] was markedly hypoxic."

Dr. Rasmussen assessed the Claimant as totally disabled. With respect to a pulmonary diagnosis, he wrote:

> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis, although not classically coal workers' pneumoconiosis, nonetheless, it is medically reasonable to conclude the patient has occupational pneumoconiosis which arose as a consequence of his

coal mine dust exposure.

Citing medical literature and epidemiological studies, Dr. Rasmussen concluded that Mr. Childers "has a totally disabling respiratory insufficiency which is the consequence of both the cigarette smoking and the coal mine dust exposure. His coal mine dust exposure is a major contributing factor." (DX-49). Dr. Rasmussen is board-certified in internal medicine and is a B-reader. He has been a Visiting Assistant Professor of Internal Medicine at the Meharry Medical College and between 1978 and 1988 was a Clinical Assistant Professor of Medicine, Marshall University School of Medicine. (DX-49).

Dr. J. Randolph Forehand. Dr. Forehand examined the Claimant at the request of the Department of Labor. (DX-9). Dr. Forehand recorded a smoking history of 50 pack/years, and a coal mine employment history of 22 years. On examination of the chest, the doctor observed diminished breath sounds on auscultation. He diagnosed coal workers' pneumoconiosis and chronic bronchitis, and attributed these conditions to coal dust exposure and smoking. Both impairments contributed to the Claimant's total respiratory disability.

Dr. Forehand interpreted the ventilatory study results as showing an obstructive ventilatory pattern. He disagreed with negative rereadings of the November 7, 2000 x-ray that he had read as positive, and reiterated his opinion that the Claimant has pneumoconiosis. (DX-10).

Dr. Emory Robinette. Dr. Robinette has been the Claimant's treating physician since October 1998. He examined the Claimant in October, 1998, and issued his report on November 23, 1998. (DX-35). Mr. Childers complained of various respiratory complaints, including the need for continued oxygen therapy. The review of systems included a reference to sleep studies and increasing weight. On physical examination of the chest, Dr. Robinette observed diminished breath sounds, bilateral expiratory wheezes and rhonchi in both lung fields. He saw no obvious clubbing or cyanosis.

Dr. Robinette referred to a chest x-ray that showed "1/2" Q/T opacities. The pulmonary function study results were consistent with a "moderate obstructive lung disease without response to bronchodilator therapy." Air trapping was indicated, and Dr. Robinette thought that this was consistent with emphysema. There was also a "marked impairment of diffusion capacity." The doctor concluded that Mr. Childers suffers from "pneumoconiosis with a profusion abnormality of 1/2, predominant Q/T opacities with discoid atelectasis and pleural parenchymal scarring." He also opined that the Claimant has "[s]evere obstructive lung disease with severe hypoxemia and elevation of his carboxyhemoglobin level." In addition to orthpedic conditions, the Claimant also had "[p]robable sleep apnea syndrome." He summarized:

> It is my medical opinion that Mr. Childress [sic] has radiographic findings consistent with coal workers' pneumoconiosis. Radiographic abnormalities are consistent with his 20 years of dust exposure. Moreover, he has evidence of severe obstructive ventilatory defect with marked impairment of his diffusion capacity and has intercurrent hypoxemia. Mr. Childress is obviously disabled[.] ... His condition appears to be chronic and irreversible and is probably progressive in nature.

Dr. Robinette is board certified in internal medicine, with a subspecialty in pulmonary disease, and is a B-reader.

Treatment Notes

The Claimant submitted miscellaneous treatment notes from his treating physician, Dr.

Emory Robinette. (CX-2, DX-35). For purposes of evaluating this duplicate claim, only those notes will be considered that reflect treatment or evaluation subsequent to March 15, 1999, the date on which the Claimant's previous claim was finally denied when the denial of benefits was affirmed by the Board.

Dr. Robinette evaluated the Claimant on June 9, 1999. He noted for background that he had previously interpreted a chest x-ray as demonstrating 1/2 pneumoconiosis. The doctor also thought that Mr. Childers had severe pulmonary disease.

On physical examination, Dr. Robinette observed diminished breath sounds on auscultation with bilateral wheezes. He also noted a "moderate prolongation of the expiratory phase." There was no cyanosis in examination of the extremities. Dr. Robinette proscribed additional medication to assist Mr. Childers in his breathing.

Dr. Robinette on June 29, 1999 interpreted the results of the exercise arterial blood gas and pulmonary function testing as

> "consistent with moderate obstructive lung disease without response to bronchodilator therapy, with normal lung volumes. There is severe impairment of the diffusion capacity and evidence of profound oxygen desaturation with exercise, with inadequate oxygenation despite maximum liter-flow of supplemental oxygen.

Office notes from December 6, 1999 show that "diminished breath sounds with bilateral inspiratory crackles" and a "marked prolongation of the expiratory phase" were observed on examination. Dr. Robinette noted that the Claimant "certainly needs to refrain from smoking."

Dr. Robinette saw the Claimant on March 6, 2000 for a "follow-up of his underlying black lung disease with pulmonary fibrosis and intercurrent hypoxemia." The doctor noted Mr. Childers' "profound oxygen desaturation with exercise" and "some increasing peripheral edema." The physical examination showed diminished breath sounds and bilateral expiratory wheezes. Dr. Robinette reported that the chest x-ray showed "evidence of mild fibrosis."

Subsequent visits, on June 29 and October 30, 2000, resulted in similar findings on physical examination. Dr. Robinette noted on February 28, 2001 that there were some components of sleep apnea, and referred to a scheduled sleep study. The doctor noted on June 29, 2001 that the Claimant's "black lung disease is relatively stable at this time but he is obviously oxygen dependent and his condition is irreversible."

On December 28, 2001 Dr. Robinette examined the Claimant. His notes show a concern for an abnormal chest x-ray interpreted by Dr. Rasmussen which "demonstrated evidence of a right hilar opacity with a superimposed background of pneumoconiosis." Physical examination of the chest resulted in findings similar to those found in earlier examinations. A CT scan of the thorax region was requested to "document the right hilar opacity and exclude the development of a mass effect in this region."

Follow-up notes from a visit on June 26, 2002 show a concern for a "positive PPD superimposed on underlying black lung disease and severe airflow obstruction." A physical examination of the chest resulted in findings similar to previous examinations. Notes from the December 16, 2002 visit reflect that the Claimant had been treated for a positive PPD. Findings from this, and the later visit on April 23, 2003, are consistent with those from earlier examinations.

Dr. Robinette emphasized after a visit on September 11, 2003 that the Claimant "has evidence of interstitial lung disease related to his black lung." On January 13, 2004, the physical

examination again revealed diminished breath sounds, crackles and wheezes.

DISCUSSION

Responsible Operator

Mr. Childers also testified that he was last employed in mining with Bobby Childers Trucking Company. In its post-hearing brief, the Employer asserts that the Claimant's testimony now shows that he did not engage in coal mine employment while he operated this company because he recalled that he delivered coal in its finished form from processing plants to ultimate consumers in Virginia, West Virginia and Kentucky.

I disagree with Employer's reading of the Claimant's testimony. Although Mr. Childers stated that he hauled finished coal in responses to questions posed on redirect examination, I have reviewed his testimony in prior hearings in which he claimed to have hauled coal to processing plants. I specifically find as a matter of fact that the Claimant's testimony in the various hearings can be reconciled. Although he most recently testified to one aspect of his employment wherein he hauled coal after it was processed, work that does not constitute coal mine employment, see ***Southard v. Director, OWCP***, 732 F.2d 66, 69-70, 6 B.L.R. 2-26 (6th Cir. 1984); cf. ***Johnson v. Jeddo-Highland Coal Co***., 12 B.L.R. 1-53 (1988) (claimant's work weighing trucks that hauled processed coal not coal mine employment), this does not undermine earlier testimony in which Mr. Childers described in detail hauling unprocessed coal between mines and processing plants. I find that Bob Childers Trucking is the responsible operator liable for the payment of benefits.

Territorial Jurisdiction

There has been no dispute up to this point as to the issue of where the Claimant suffered his last coal mine dust exposure. Nevertheless, the Claimant's current hearing testimony casts doubt on the assumption that this is a Fourth Circuit claim. The appropriate jurisdiction will determine the federal circuit law that must apply in the adjudication of Mr. Childers' claim. *See generally* ***Shupe v. Director, OWCP***, 12 B.L.R. 1-200 (1989) (en banc). The decision whether to apply Fourth Circuit or Sixth Circuit law in the adjudication of this claim would affect two standards. In order to determine whether a miner has established the existence of pneumoconiosis, the Fourth Circuit requires that the adjudicator weigh all of the evidence together in reaching a finding as to whether a miner has established that he has pneumoconiosis at 20 C.F.R. § 718.202(a). ***Island Creek Coal Co. v. Compton***, 211 F.3d 203, 211, 22 B.L.R. 2-162 (4th Cir. 2000). For a claim that arises within the territorial jurisdiction of the Sixth Circuit, a claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at 20 C.F.R. §718.202(a). See ***Furgerson v. Jericol Mining, Inc***., 22 B.L.R. 1-216 (2002) (en banc).

Based on the Claimant's testimony, it is difficult to establish with certainty the location of his last coal mine employment. Bob Childers Trucking is listed on Social Security Earnings records as operating in Virginia. Nevertheless, in view of testimony that the Claimant would deliver coal to sites in Kentucky, I find that his last qualifying coal mine employment occurred in Kentucky, and shall apply Sixth Circuit law in the adjudication of this duplicate claim. [20]

[20] The standard for establishing the existence of pneumoconiosis is frankly less stringent under Sixth Circuit law, because a finding of pneumoconiosis can be based on any one of the alternative methods set forth at 20 C.F.R. § 718.202(a). Moreover, although the "material change" standard for Sixth Circuit duplicate claims is more difficult to meet, I conclude that on this record, a finding that the Claimant would now be afflicted with pneumoconiosis

Timeliness

As stated above, this claim arises within the territorial jurisdiction of the Sixth Circuit. In ***Tennessee Consolidated Coal Co. v. Kirk***, 264 F.3d 602, 22 B.L.R. 2-288 (6th Cir. 2001), that court held:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and, pursuant to [Ross], the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are supported by a medical determination ... and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course he may continue to pursue pending claims.

Kirk, 244 F.3d at 608. The Board in ***Furgerson v. Jericol Mining, Inc***., 22 B.L.R. 1-216 (2002) (en banc) concluded that this language constitutes a holding, and not mere dicta, with respect to duplicate and subsequent claims arising within the territorial jurisdiction of that circuit.

Section 728.308 of the Secretary's regulations in part sets forth a rebuttable presumption that every claim for benefits is timely. 20 C.F.R. § 725.308. I find that this presumption has not been rebutted by evidence of record. In the hearing before Judge DeGregorio on June 20, 1995, the Claimant testified that he did not know whether his physician used the words "disabled with black lung[.]" (DX-28-57 at 21). At the second hearing, held on March 5, 2002, the Claimant recalled that he did not think his physician, Dr. Baxter, told him he was disabled by black lung. Mr. Childers testified that he did not receive the doctor's files. (DX-36 at 27). At the hearing before the undersigned conducted on May 12, 2004, the Claimant believed that he had been "disabled" by Dr. Kabaria, who did not permit the Claimant to obtain his commercial driver's license. (Tr. at 19-20). Mr. Childers did not receive any medical report to that effect.

I find that there is no clear indication from this record that the Claimant received an adequate medical determination of total disability due to pneumoconiosis. I find that the instant duplicate claim is timely.

Material Change in Conditions

After the expiration of one year from the denial of the previous claim, a duplicate claim must be denied on the basis of the prior denial unless a miner demonstrates with the submission of additional evidence generated subsequent to the final denial of the previous claim a material change in conditions. 20 C.F.R. § 725.309(d). To assess whether this change is established, the administrative law judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. See ***Sharondale Corp. v. Ross***, 42 F.3d 993, 997-98, 19 B.L.R. 2-10 (6th Cir. 1994). *See also* ***Lisa Lee Mines v. Director, OWCP*** [Rutter], 86 F.3d 1358, 1362-63, 20 B.L.R. 2-227 (4th Cir. 1996) (en banc), cert. denied, 519 U.S. 1090 (1997). The Board has ruled that the focus of the material change standard is on specific findings made against the

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would be based on evidence that differs qualitatively from that previously submitted.

miner in the prior claim; an element of entitlement which the prior administrative law judge did not explicitly address in the denial of the prior claim does not constitute an element of entitlement "previously adjudicated against a Claimant." See ***Allen v. Mead Corp***., 22 B.L.R. 1-63 (2000) (en banc). For a Sixth Circuit claim, the newly submitted evidence must also differ qualitatively from the previously submitted evidence. See ***Grundy Mining Co. v. Director, OWCP*** [Flynn], 353 F.3d 467, 23 B.L.R. 2-44 (6th Cir. 2003); ***Chaffin v. Peter Cave Coal Co.***, 22 B.L.R. 1-294 (2003).

If a Claimant establishes the existence of that element, he has demonstrated, as a matter of law, a material change in conditions, and would then be entitled to a full adjudication of his claim based on the record as a whole. Rutter, 86 F.3d at 1362-63. See ***Tennessee Consolidated Coal Co. v. Kirk***, 264 F.3d 602, 608, 22 B.L.R. 2-288 (6th Cir. 2001)

In this case, the previous claim was denied by the administrative law judge because the Claimant failed to establish pneumoconiosis or disability causation. Because there is no dispute that the Claimant is totally disabled, the evidence must be evaluated to determine whether he suffers from pneumoconiosis, and whether his total respiratory disability is due to pneumoconiosis.

This claim also involves Claimant's petition for modification of the duplicate claim. Section 22 of the Longshore and Harbor Workers' Compensation Act provides in part that "upon his own initiative, or upon the application of any party ... on the ground of a change in conditions or because of a mistake in a determination of fact ... the [fact-finder] may, at any time ... prior to one year after the rejection of a claim, review a compensation case ... ." See 33 U.S.C. § 922, as incorporated by 30 U.S.C. § 932(a) and implemented by 20 C.F.R. § 725.310. This provision should be read broadly. See ***O'Keeffe v. Aerojet-General Shipyards, Inc.***, 404 U.S. 254, 255 (1971). Because the Claimant has requested modification of a duplicate claim, the undersigned is required to review the entire duplicate claim record, viz. all of the new evidence generated subsequent to the final denial of Mr. Childers' first claim, to determine whether the denial of the duplicate claim was mistaken, or that the modification evidence demonstrates a change in condition.

Pneumoconiosis

Under the Act, to receive benefits, a claimant must prove several facts by a preponderance of the evidence. First, the coal miner must establish the presence of pneumoconiosis.[21]

Pneumoconiosis under the Act is defined as both clinical pneumoconiosis and/or any respiratory or pulmonary condition significantly related to or significantly aggravated by coal dust exposure:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or

[21] 20 C.F.R. § 718.201.

pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

20 C.F.R. § 718.201.

Note that the definition appears to combine the first two elements of entitlement, pneumoconiosis and cause of pneumoconiosis. However, the miner bears the burden of establishing both that he or she has pneumoconiosis and that the pneumoconiosis arose out of coal mine employment.

There are four methods for determining the existence of pneumoconiosis:

(1) Under 20 C.F.R. § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence.

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence.

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis; § 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a)(4).

Because this claim arises within the territorial jurisdiction of the Sixth Circuit, a claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at 20 C.F.R. §718.202(a). See ***Furgerson v. Jericol Mining, Inc.***

There is no evidence relevant to § 718.202 (a)(2). Accordingly, the Claimant can not establish the existence of pneumoconiosis under this section. Further, none of the enumerated presumptions apply in this case under § 718.202(a)(3). I will therefore turn to the x-ray and medical opinion evidence to determine whether the Claimant has established the presence of pneumoconiosis under either provision for purposes of this subsequent claim.

X-Ray Evidence

The duplicate claim record includes the interpretations of ten chest x-rays that were developed after the Board's affirmance of the denial of the Claimant's initial claim. The most recent film, taken on April 2, 2004, was read as positive by Dr. DePonte and negative by Dr. Scott. Both radiologists are dually qualified as board-certified B-readers. Dr. Scott also possesses academic qualifications. I consider the readings equally probative, and find that the Claimant has not proven that this film is positive for pneumoconiosis.

The next most recent film was taken on September 10, 2003. Dr. Castle interpreted this film as showing "1/0." Although he has explained that this is not a positive film, I find to the contrary.

I shall credit the negative rereadings of the April 23, 2003 and December 31, 2001 x-rays by Drs. Wheeler and Scatarige on the basis of their credentials. There are no classified positive interpretations of these films.

The December 4, 2001 x-ray was read as positive by Dr. Patel, and reread as negative by Drs. Scatarige and Wheeler. All of these readers are dually qualified as board-certified radiologists and B-readers. At best, the interpretations of this x-ray are equally probative, and, as a result, this x-ray is not positive for the existence of pneumoconiosis.

I find that the chest x-rays of October 19, 2001 and May 4, 2001 are negative. I shall defer to the negative rereadings of the former film by Drs. Scott, Wheeler and Scatarige on the basis of their credentials. Dr. DePonte apparently offered a positive narrative reading of the October x-ray, and there is no positive interpretation of the May 4, 2001 film.

Dr. Forehand interpreted the November 7, 2000 x-ray as positive, "2/1". (DX-12). This film was reread as "0/1" by Dr. Ranavaya, and negative by Drs. Barrett, Wheeler and Scott. I shall defer to the interpretations by the latter radiologists on the basis of their credentials. The single positive interpretation of this film does not show the presence of pneumoconiosis by a preponderance of the evidence.

The March 6, 2000 film was uniformly interpreted as negative. Similarly, although Dr. Mullens offered a narrative report, I am not persuaded that this x-ray demonstrates the existence of the disease. I also defer to the negative rereadings of this film by Drs. Wheeler and Scott on the basis of their credentials.22

Certainly, I am not required to defer to the numerical superiority of x-ray evidence. ***Wilt v. Wolverine Mining Co***., 14 B.L.R. 1-70 (1990). See also Tokarcik v. Consolidation Coal Co., 6 B.L.R. 1-666 (1984). Moreover, I should not blindly defer to later x-rays, especially where an earlier film is positive. See ***Adkins v. Director, OWCP***, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). On balance, however, especially given the overall superiority of the credentials of the Employer's experts as well as the Claimant's burden of persuasion, I find that, given the preponderance of the interpretations, the x-ray evidence does not establish pneumoconiosis. See generally ***Napier v. Director, OWCP***, 89 F.2d 669, 671, 13 B.L.R. 2-117 (4th Cir. 1989); ***Edmiston v. F&R Coal Co.***, 14 B.L.R. 1-65 (1990). In the final analysis, and mindful of a qualitative, as well as a quantitative, evaluation of the x-rays, see ***Woodward v. Director, OWCP***, 991 F.2d 314, 321, 17 B.L.R. 2-77 (6th Cir. 1993), I find that the Claimant has not established the presence of pneumoconiosis at Section 718.202(a)(1) on the basis of chest x-rays.

Medical Opinion Diagnosis

I turn next to the question of whether the Claimant has demonstrated the existence of pneumoconiosis on the basis of a reasoned medical opinion diagnosis of the disease, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a)(4). The opinions of three physicians, Drs. Forehand, Rasmussen and Robinette, as well as the CT scan interpretations by Drs. Coburn and Mullens form the strongest case on behalf of this claim.

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[22] The duplicate claim record also contains interpretations of x-rays taken on October 27 and September 17, 1998. Dr. Robinette interpreted the former as positive, and Dr. Mullens offered a narrative report. (DX-35). This film was reread as "0/1" by Dr. Castle (DX-34) and negative by Drs. Scott and Wheeler. (DX-17, DX-18).

Initially, I discount the diagnoses by Drs. Forehand, Rasmussen and Robinette to the extent their conclusions, that Claimant has pneumoconiosis, rest in principal part on a positive x-ray that has been reread as negative. See ***Winters v. Director, OWCP***, 6 B.L.R. 1-877 (1984). While a medical opinion diagnosis of pneumoconiosis may be sufficient notwithstanding a negative x-ray, see ***Taylor v. Director, OWCP***, 9 B.L.R. 1-22 (1996), where x-ray evidence constitutes a major part of the physician's documentation, his opinion may be entitled to diminished probative weight if that film has been reread as negative. Cf. Director, ***OWCP v. Rowe***, 710 F.2d 251, 255 n. 6, 5 B.L.R. 2-99 (6th Cir. 1983) (validity of opinion discounted because doctor relied on x-ray found to be unreadable).

I am mindful that Dr. Robinette has been the Claimant's treating physician, and diagnosed pneumoconiosis, citing a positive chest x-ray. (DX-35). I also note his dual certification in internal and pulmonary medicine, as well as his status as a B-reader. I have carefully evaluated this expert's opinions in view of his familiarity of Mr. Childers' pulmonary condition. Indeed, he has consistently observed "positive" findings on examination of the chest during the numerous office visits, and the results from his pulmonary function studies do not show the reversibility cited by the Employer's experts as one reason for concluding that Mr. Childers' obstructive pulmonary impairment is not derived from coal mine dust exposure. The Secretary's regulations require an examination into the "nature of the relationship" between the physician and the patient, its duration and both frequency and extent of treatment. 20 C.F.R. § 718.104(d)(1) - (4). The regulation, which applies to the instant claim, also provides that:

> [i]n appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudicative officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

20 C.F.R. § 718.104(d)(5).

Nevertheless, in the final analysis, the credibility of the treating physician's opinion may primarily rest on its "power to persuade." ***Eastover Mining Co. v. Williams***, 338 F.3d 501, 513 (6th Cir. 2003). If a treating physician's opinion is not credible, an administrative law judge need not accord additional weight to the treating physician's opinion. See 20 C.F.R. § 718.104(d)(5). See also ***Jericol Mining, Inc. v. Napier***, 311 F.3d 703 (6th Cir. 2002); ***Wolfe Creek Collieries v. Director, OWCP*** [Stephens], 298 F.3d 511 (6th Cir. 2002); ***Peabody Coal Co. v. Groves***, 277 F.3d 834, 22 B.L.R. 2-320 (6th Cir. 2002). Although Dr. Robinette has examined the Claimant on numerous occasions, he does not offer a persuasive analysis – outside the positive x-ray – to explain his diagnosis of coal workers' pneumoconiosis, or to show that Mr. Childers' chronic obstructive pulmonary disease constitutes legal pneumoconiosis and not the effects of Mr. Childers' smoking, asthma, or obesity.

I also note that Dr. Rasmussen is particularly well qualified, with board certification and vast clinical experience. Cf. ***Martin v. Ligon Preparation Co***., 400 F.3d 302, 307 (6th Cir. 2005) (credentials of pulmonary specialist not necessarily superior to those of internist – Dr. Rasmussen - who nevertheless established extensive clinical experience in pulmonary medicine and coal workers' pneumoconiosis). His diagnosis of pneumoconiosis likewise relies in great part, however, on a positive x-ray reading by Dr. Patel that has been reread as negative by Drs. Wheeler and Scatarige. Further, his examination of the chest revealed no wheezes, rales or

rhonchi. Dr. Rasmussen characterized the breath sounds as "normal." He also saw no clubbing and no edema. The pulmonary function study that was administered by Dr. Rasmussen also showed improvement in the FEV1 and FVC values. The doctor characterized the results as showing a "partially reversible obstructive ventilatory impairment." This reversibility was one reason why the Employer's experts, especially Dr. Castle, opined that the Claimant's obstructive pulmonary impairments were not coal workers' pneumoconiosis.

I also find that the CT scan readings by Drs. Coburn and Mullens are less persuasive on the issue of coal workers' pneumoconiosis than the interpretations of these studies by Drs. Scatarige and Wheeler, who hold impressive credentials. I credit the negative interpretations of the CT scans by the Employer's experts on the basis of their credentials. The CT scan evidence is also evaluated at Section 718.202(a)(4) and is also weighed against the opinion evidence introduced in support of this claim.

Moreover, I will credit the medical opinions of the Employer's physicians, especially those by Dr. Castle. I find as a fact that his opinions are more thoroughly explained and somewhat better supported by the clinical documentation. Dr. Castle offers the most thoroughly explained and persuasive medical opinion in this record. His assessments and diagnoses are best supported by underlying documentation. See generally ***Clark v. Karst-Robbins Corp.***, 12 B.L.R. 1-149 (1989)(en banc); ***Lucostic v. United States Steel Corp.***, 8 B.L.R. 1-46 (1985). Further, Dr. Castle, in addition to personally evaluating the Claimant, also has the advantage of an extensive review of the Claimant's medical records, including the opinions of the other experts of record. See ***Balsavage v. Director, OWCP***, 295 F.3d 390, 396, 22 B.L.R. 2-386 (3d Cir. 2002). Dr. Castle pointed out that the Claimant did not exhibit physical findings on his examination that would be characteristic of an interstitial pulmonary process as would be expected with pneumoconiosis. He cited the reversibility of the ventilatory test results on his studies, and noted as well that the Claimant had complained of sensitivity to flowers and hair sprays that would indicate an asthmatic process.[23]

In the final analysis, I find that the medical opinions of Dr. Castle, corroborated to a lesser extent by Drs. Dahhan and Fino, as well as by the CT scan interpretations by Drs. Wheeler and Scatarige, are sufficient to preclude a finding of pneumoconiosis at Section 718.202(a)(4). Again, the x-ray documentation that forms a basis for these opinions tends to support the opinions that Mr. Childers does not have pneumoconiosis. There is no persuasive medical opinion diagnosis of coal workers' pneumoconiosis notwithstanding a negative x-ray. The Claimant's experts do not offer a persuasive explanation that the obstructive pulmonary impairment suffered by him constitutes coal workers' pneumoconiosis as that disease is broadly defined in the Act and its implementing regulations. Dr. Castle's medical opinions, as presented in written report and through deposition testimony, are at the least equally probative with the medical opinions offered in support of this claim.

In addition to the fact that the positive x-rays upon which the Claimant's experts rely have been persuasively reinterpreted as negative, the reports and conclusions from Dr. Castle are more thorough. I find, therefore, that, even taking the evidence as equally probative, the Claimant has failed to establish the existence of pneumoconiosis at Section 718.202(a)(4). This conclusion takes into account the "qualifications of the respective physicians, the explanations of

[23] The ventilatory results obtained by Dr. Castle and Rasmussen on December 4, 2001, showed this improvement, as did the pulmonary function study conducted on November 7, 2000 by Dr. Forehand. Tests conducted by Dr. Robinette on June 24, 1999 and October 27, 1998, however, did not show reversibility after the administration of bronchodilators.

their medical opinions, the documentation underlying their medical judgments and the sophistication and bases of their diagnoses." See ***Sterling Smokeless Coal Co. v. Akers***, 131 F.3d 438, 441, 21 B.L.R. 2-269 (4th Cir. 1997).

CONCLUSION

First, examining the duplicate claim on modification, I find that the newly submitted evidence, taken in conjunction with the previously submitted duplicate claim evidence, does not demonstrate a change in condition. Reviewing the duplicate claim evidence as a whole, I also find that the Claimant has failed to establish a mistake in Administrative Law Judge Levin's determination that he did not prove a material change.[24]

Because the Claimant has not proven that he suffers from pneumoconiosis, or any pulmonary or respiratory impairment significantly related to, or substantially aggravated by, coal mine dust exposure, I find that he has failed to establish a material change in conditions. I thus conclude that he is not entitled to benefits under the Act because this claim is barred pursuant to Section 725.309(d).

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of attorney's fees to the Claimant for representation services rendered in pursuit of the claim.

ORDER

It is hereby **ORDERED** that the claim of Bobby Childers is **DENIED**.

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DANIEL F. SOLOMON
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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[24] I also note that the adjudicator must also determine whether reopening a duplicate claim on the basis sought by the Claimant would render justice under the Act. Modification will be appropriate whenever "changed conditions or a mistake in a determination of fact makes such modification desirable in order to render justice under the act." ***Bath Iron Works, Inc. v. Director, OWCP*****,** 244 F.3d 222, 227 (1st Cir. 2001) (citing ***O'Keeffe v. Aerojet-General Shipyards, Inc.,*** 404 U.S. 254, 255 (1971) (per curiam)). *See* ***Betty B Coal Co. v. Director, OWCP*** [***Stanley***], 194 F.3d 491, 497-98, 22 B.L.R. 2-1 (4th Cir. 1999). *See generally,* ***McCord v. Cephas*****,** 532 F.2d 1377, 1380-81, 3 BRBS 371 (D.C. Cir. 1976). In view of the disposition of this case, I need not reach this question.